MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2005 INDIVIDUAL HOSPITAL APPLICATION FOR

GEOGRAPHIC RECLASSIFICATION EFFECTIVE FEDERAL FISCAL YEAR (FFY) 2007

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY **5:00 P.M. EDT, SEPTEMBER 1, 2005**. FAILURE TO COMPLY WILL RESULT IN DISMISSAL

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

I. HOSPITAL INFORMATION

1. NAME OF HOSPITAL: _____

2. MEDICARE PROVIDER NUMBER: _____

3. STREET ADDRESS: _____

_____

_____ ZIP CODE

4. NAME OF THE COUNTY WITHIN WHICH THE HOSPITAL IS LOCATED:

_____

5. MAILING ADDRESS AND CONTACT NAME AND TELEPHONE NUMBER FOR ALL COMMUNICATIONS REGARDING THE APPLICATION:

(ORGANIZATION) _____

(PERSON) _____

(ADDRESS) _____

_____

_____ ZIP CODE -

(TELEPHONE NUMBER) _____

II. RECLASSIFICATION REQUEST

NOTE: PLEASE READ THE INDIVIDUAL HOSPITAL INSTRUCTIONS FOR THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS.

6. CIRCLE THE RECLASSIFICATION AND CRITERIA CATEGORY USED FOR THE APPLICATION

A. WAGE INDEX VALUE - (42 C.F.R. §§ 412.230(d)(l)(iii) AND (iv)
1. HOSPITALS LOCATED IN RURAL AREAS - 106 AND 82 PERCENT
2. HOSPITALS LOCATED IN URBAN AREAS - 108 AND 84 PERCENT

B. WAGE INDEX VALUE - DOMINATING HOSPITAL EXCEPTION (42 C.F.R. § 412.230(d)(4))

7. SEEKS RECLASSIFICATION FROM: _____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE or URBAN AREA.)

SEEKS RECLASSIFICATION TO: _____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE or URBAN AREA.)

III. GENERAL INFORMATION

8. A. IS THE HOSPITAL ALREADY RECLASSIFIED FOR FFY 2007 FOR THE WAGE INDEX UNDER A 3-YEAR WAGE INDEX RECLASSIFICATION?

YES _____ NO _____

B. IF "YES" to 8.A., WHAT RURAL OR URBAN AREA IS THE HOSPITAL RECLASSIFIED TO FOR FFY 2007 UNDER ITS 3-YEAR WAGE INDEX RECLASSIFICATION?

_____

(SHOW THE NAME AND IDENTIFICATION CODE FOR THE STATE or URBAN AREA.)

9. A. IF THE HOSPITAL WAS RECLASSIFIED FOR THE WAGE INDEX VALUE FOR FFY 2007 THROUGH A PRIOR 3-YEAR RECLASSIFICATION, DID THE HOSPITAL "WITHDRAW" OR "TERMINATE" SUCH RECLASSIFICATION?

YES _____ NO _____

B. IF THE ANSWER TO 9.A. IS "YES," DID THE HOSPITAL APPLY TO CANCEL A BOARD APPROVED "WITHDRAWAL" OR "TERMINATION?"

YES _____ NO _____

10. A. PRIOR YEAR CASE NUMBERS (ALL HOSPITALS MUST COMPLETE):

04C_____ 05C_____ 05F_____ 06C_____

B. PRIOR YEAR CASE NUMBERS – (ONLY HOSPITALS APPLYING FOR THE SPECIAL DOMINATING HOSPITAL EXCEPTION MUST COMPLETE)

90C_____ 91C_____ 92C_____ 93C_____

94C_____ 95C_____

11. A. IS THE HOSPITAL ALSO A MEMBER OF A GROUP RECLASSIFICATION REQUEST?

YES _____ NO _____

B. IF "YES" TO 11.A, ENTER THE NAME OF THE COUNTY IN WHICH THE GROUP IS LOCATED:

_____

C. IS THE HOSPITAL ALSO A MEMBER OF A STATEWIDE WAGE INDEX AREA REQUEST?

YES _____ NO _____

GENERALLY, THE BOARD WILL RULE ON ANY STATEWIDE WAGE INDEX APPLICATION FIRST, AND THEN THE GROUP APPLICATION BEFORE IT REVIEWS THE INDIVIDUAL REQUEST.

12. IF THE HOSPITAL APPLYING FOR RECLASSIFICATION IS AN URBAN HOSPITAL:

A. IS THE HOSPITAL CURRENTLY CLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 CFR § 412.103 AS BEING IN A RURAL AREA?

YES _____ NO _____

B. DOES THE HOSPITAL HAVE A PENDING APPLICATION WITH THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA UNDER 42 CFR § 412.103?

YES _____ NO _____

IF "YES" TO 12A, PROVIDE A COPY OF THE CMS REGIONAL OFFICE APPROVAL LETTER AT **ATTACHMENT A**.

13. INDICATE WHETHER THE HOSPITAL IS CURRENTLY CLASSIFIED AS A:

A. SOLE COMMUNITY HOSPITAL (SCH) YES _____ NO _____

IF "YES," ATTACH A CURRENT LETTER FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY CONFIRMING THE HOSPITAL'S CURRENT STATUS AS A SOLE COMMUNITY HOSPITAL UNDER **ATTACHMENT B**. ALSO, PROVIDE A COPY OF THE LETTER FROM CMS OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT GRANTED SCH STATUS TO THE HOSPITAL UNDER **ATTACHMENT B**.

B. HAS THE HOSPITAL LOST ITS DESIGNATION AS A SOLE COMMUNITY HOSPITAL DUE TO AN MGCRB RECLASSIFICATION IN A PREVIOUS YEAR?

YES _____ NO _____

IF "YES," IDENTIFY THE DATE STATUS WAS LOST: _____

ATTACH THE FISCAL INTERMEDIARY OR CMS REGIONAL OFFICE LETTER INDICATING WHEN THE HOSPITAL'S SCH STATUS WAS LOST UNDER **ATTACHMENT C**.

14. **A**. INDICATE WHETHER THE HOSPITAL IS CURRENTLY CLASSIFIED AS A:

RURAL REFERRAL CENTER YES _____ NO _____

B. IF THE ANSWER TO 14.A. IS "NO," INDICATE WHETHER THE HOSPITAL "HAS EVER BEEN" CLASSIFIED AS A:

RURAL REFERRAL CENTER YES _____ NO _____

IF "YES" TO 14.A. or 14.B., PROVIDE A COPY OF THE OFFICIAL LETTER FROM THE CMS REGIONAL OFFICE OR THE HOSPITAL'S FISCAL INTERMEDIARY THAT GRANTED RURAL REFERRAL CENTER STATUS TO THE HOSPITAL UNDER **ATTACHMENT D.**

15. INDICATE WHETHER THE HOSPITAL IS REQUESTING AN ORAL HEARING:

YES _____ NO _____

ATTACH RATIONALE FOR REQUEST UNDER **ATTACHMENT E**.

IV. RECLASSIFICATION REQUEST UNDER SPECIAL ACCESS RULES FOR SOLE COMMUNITY HOSPITALS AND RURAL REFERRAL CENTERS

16. IF THE HOSPITAL IS A SOLE COMMUNITY HOSPITAL OR A RURAL REFERRAL CENTER AND IS APPLYING UNDER THE SPECIAL ACCESS RULES, IS IT APPLYING TO THE CLOSEST URBAN OR THE CLOSEST RURAL AREA (IF THE RURAL AREA IS CLOSER THAN THE CLOSEST URBAN AREA)?

YES _____ NO _____

17. INDICATE WHETHER THE AREA REQUESTED IS CLOSEST IN MILES, DRIVING TIME OR BOTH AS COMPARED TO THE NEXT CLOSEST URBAN OR RURAL AREA:

_____

A. BEGINNING AT THE HOSPITAL ENTRANCE, SHOW EACH ROAD AND RELATED MILES TO THE AREA THAT IS CLOSEST IN DISTANCE OVER IMPROVED ROADS. IF THE HOSPITAL NEEDS TO COMPLETE B. BELOW, ALSO COMPLETE THE TIME COLUMN, RELATING THE DRIVING TIME TO THE ENTRIES IN THE FIRST TWO COLUMNS. **ATTACH A CLEARLY MARKED ORIGINAL MAP OR MAPS WITH LEGEND(S) UNDER ATTACHMENT F.**

ROAD	MILEAGE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL		_____

B. IF THE HOSPITAL REQUESTS RECLASSIFICATION BASED ON SHORTEST DRIVING TIME RATHER THAN DISTANCE (SEE ITEM A), IT MUST COMPLETE ALL THREE COLUMNS. **ATTACH A CLEARLY MARKED ORIGINAL MAP OR MAPS WITH LEGEND(S) UNDER ATTACHMENT F.**

ROAD	MILEAGE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL	_____	_____

V. RECLASSIFICATION REQUEST UNDER PROXIMITY RULES

18. IS THE HOSPITAL LOCATED WITHIN 35 MILES, IF A RURAL HOSPITAL, OR 15 MILES, IF URBAN, OF THE AREA TO WHICH IT SEEKS RECLASSIFICATION?

YES _____ NO _____

19. IF "YES" TO 18, SHOW THE NUMBER OF MILES OVER IMPROVED ROADS FROM THE HOSPITAL ENTRANCE TO THE BORDER OF THE REQUESTED AREA. **ATTACH A CLEARLY MARKED ORIGINAL MAP OR MAPS WITH LEGEND(S) UNDER ATTACHMENT F.**

ROAD	MILEAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
TOTAL	_____

20. IF THE URBAN HOSPITAL IS LOCATED MORE THAN 15 MILES FROM THE REQUESTED AREA OR THE RURAL HOSPITAL IS LOCATED MORE THAN 35 MILES FROM THE REQUESTED AREA, INDICATE, IF APPLICABLE, WHETHER AT LEAST 50 PERCENT OF ITS EMPLOYEES RESIDE IN THE AREA TO WHICH THE HOSPITAL REQUESTS RECLASSIFICATION:

YES _____ NO _____

IF "YES," ATTACH INFORMATION FROM THE HOSPITAL'S PAYROLL RECORDS THAT IDENTIFIES THE EMPLOYEES' HOME ADDRESSES BY ZIP CODE AND ATTACH A MAP THAT SHOWS THE RELATIONSHIP OF THE ZIP CODES TO THE COUNTIES AND/OR AREAS UNDER **ATTACHMENT G**. ALSO, INDICATE THE PERCENTAGE OF HOSPITAL EMPLOYEES WHO RESIDE IN THE REQUESTED AREA:

_____%

WAGE INDEX COMPARISON

ATTACH THE HOSPITAL'S WAGE INDEX COMPUTATIONS USING 3-YEAR AVERAGE HOURLY WAGES (i.e., 106 AND 82 PERCENT COMPARISON FOR HOSPITALS LOCATED IN RURAL AREAS AND 108 AND 84 PERCENT COMPARISON FOR HOSPITALS LOCATED IN URBAN AREAS) UNDER **ATTACHMENT H**. HOSPITALS THAT WERE EVER AN RRC ARE EXEMPT FROM THE 106/108 PERCENT THRESHOLDS AND WILL ONLY BE REQUIRED TO MEET THE 82 PERCENT THRESHOLD OF THE AREA TO WHICH IT IS APPLYING (NOT THE 84 PERCENT THRESHOLD), EVEN IF IT IS LOCATED IN AN URBAN AREA.

IF APPLYING USING THE DOMINATING HOSPITAL EXCEPTION CRITERIA, THE HOSPITAL MUST INCLUDE WAGES AND HOURS FOR THE THREE YEARS USED TO CALCULATE THE WAGE INDEX FOR BOTH THE HOSPITAL AND THE AREA IN WHICH IT IS LOCATED UNDER **ATTACHMENT H**. THE HOSPITAL MUST ALSO SHOW COMPUTATIONS FOR THE 40 PERCENT AND THE 108 PERCENT COMPARISON UNDER **ATTACHMENT H**.

AFFIDAVIT

COUNTY OR PARISH OF_____

STATE OF_____

I, _____ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

(1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY _____ _____ (HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 1, 2005. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.

(2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.

(3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.

(4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE:_____

TITLE: _____

PHONE NUMBER: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____2005
(DAY) (MONTH)

_____
(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____